One Month WELL CHILD VISIT Revised March 2012 BIRTH DATE ACCOMPANIED BY/INFORMANT PREFERRED LANGUAGE Name $\square M$ \Box F ID NUMBER CURRENT MEDICATIONS DRUG ALLERGIES See other side for current medication list LENGTH (%) WEIGHT FOR LENGTH (%) HEAD CIRC (%) TEMPERATURE DATE/TIME WEIGHT (%) **BF** = Bright Futures Priority Item See growth chart. History **Physical Examination** OR ☑ = Reviewed w/Findings ☑ NL = Reviewed/Normal ☐ Previsit Questionnaire reviewed Newborn Screening UNL ☐ GENERAL APPEARANCE ☐ Child has special health care needs Hearing Screening QNL ☐ SKIN (rashes, jaundice) BF 🛘 HEAD / FONTANELLE (positional skull deformities) ____ **BF** Concerns/questions raised by _ ☐ EYES (red reflex/strabismus/appears to see) ☐ Addressed (see other side) □ None ■ EARS/APPEARS TO HEAR ■ NOSE **BF** Follow-up on previous concerns □ None □ Addressed (see other side) ■ MOUTH AND THROAT □ NECK □ LUNGS **BF** \square Medication Record reviewed and updated BF HEART ☐ FEMORAL PULSES Social/Family History □ ABDOMEN _____ **BF** Family situation ☐ HERNIA ☐ Single Parent □ GENITALIA BF Parent adjustment to new child __ ☐ Male/Testes down____ ☐ Female BF Maternal Depression ☐ Yes ☐ No _ BF □ NEUROLOGIC / GAIT (tone, strength, symmetry) PHQ 9 □ Pass ☐ Refer EXTREMITIES ☐ Pass ☐ Refer PHO₂ BF MUSCULOSKELETAL (torticollis) _____ Edinburgh □ Pass □ Refer ☐ HIPS ■ NO DYSMORPHISMS BF Observation of parent-child interaction ___ ☐ HYGIENE □ BACK BF Reaction of siblings to new child **BF** Comments BF Work plans ____ BF Child care plans _____ Heat source

BF Tobacco Exposure **Review of Systems** ☑ = NL Date of last visit Changes since last visit ____ ☐ Breast milk Nutrition: Minutes per feeding _ Hours between feeding ___ _Feedings per 24 hours ____ Problems with breastfeeding ___ ☐ Formula Ounces per feeding __ Source of water _____Vitamins/Fluoride _____ Elimination: ☐ NL_ **3RIGHT** Sleep: ☐ NL **Development** (if not reviewed in Previsit Questionnaire) ☐ SOCIAL-EMOTIONAL □ COMMUNICATIVE

*Recognizes parents' voices

*Follows parent with eyes

*Has started to smile

□ COGNITIVE

Assessment

BF
Well Child

Anticipatory Guidance

- ☑ = Discussed and/or handout given
- ☐ Identified at least one child and parent strength
- ☐ Raising Reader book given
- ☐ PARENTAL WELL-BEING
 ☐ FAMILY ADJUSTMENT
- FEEDING ROUTINES

 Breastfeeding (400 IU vitamin D
 - supplement)
 - Iron-fortified formula
 - Solid foods (wait until 4-6 months)
 - Elimination (5-8 wet diapers, 3-5 stools)
- ☐ INFANT ADJUSTMENT
- Tummy time
- Encourage daily routines
- Back to sleep
- Sleep location
- Techniques to calm

□ SAFETY

- Car safety seat (infant rear facing)
- Falls
- No strings around neck
- No shaking
- Smoke-free environment
- Sun safety

(see other side for plan, immunizations and follow-up)

*If upset, able to calm

☐ PHYSICAL DEVELOPMENT

*Able to lift head when on tummy

One Month

WELL CHILD VISIT

NAME	Male	Medical Record Number	DOB
	Female		Actual age (weeks): O 3 O 4 O 5 O 6

current Medications		
Plan		
BF Patient is up to date, based on CDC/ACIP immunization schedule. If no, immunizations given today. ImmPact2 record reflects current immunization status:	·	
☐ Immunization plan/comments	☐ Public Health Nurse referral	
☐ Ask about WIC BF Laboratory/Screening results		
Hearing screen	BF Referral to	
□ Previously done Date completed Newborn blood spot screen	BF Follow-up/Next Visit	
□ Previously done Date completed Narrative Notes:		
EXAMINER'S SIGNATURE	DATE	Department of Health and Human Services